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The Patient Protection and Affordable Care Act: A Primer for Hand Surgeons

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Abstract

The Affordable Care Act is the largest and most comprehensive overhaul of the United States healthcare industry since the inception of the Medicare and Medicaid. Contained within the 10 Titles are a multitude of provisions that will change how hand surgeons practice medicine and how they are reimbursed. It is imperative that surgeons are equipped with the knowledge of how this law will affect all physician practices and hospitals.

Keywords

Patient Protection and Affordable Care Act; Affordable Care Act; Obamacare; Healthcare Reform; Hand Surgery

Introduction

Healthcare reform in the United States has been a matter of substantial debate in presidential elections since the early 1900's (1). This evolved from an increasing awareness of patient populations without health insurance. After 8 years of deliberation, the administration of former President Lyndon B. Johnson introduced the Social Security Act in 1965. This bill established the first comprehensive national social insurance program with the creation of the Medicare (for patients over the age of 65) and Medicaid (for individuals or families with low incomes) systems (2). Despite these landmark efforts, large portions of the population remain without health insurance coverage and costs of delivering healthcare are increasing at an unsustainable rate (Figure 1). Proposed solutions to these problems have been either limited or sweeping, but almost always divisive.

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On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (more commonly known as the Affordable Care Act, or ACA) (3). Although the assurance of healthcare coverage for every American is the prime directive, numerous provisions within the bill aim to control costs and improve healthcare quality in the United States (4) (Box 1). The ultimate effects of the ACA on healthcare in the United States remain an area of considerable uncertainty. Because of the broad scope of this bill, it has far-reaching implications for hand surgeons including new quality benchmarks and changing reimbursement structures.

The 905-page ACA bill, as originally written, was comprised of 10 Titles scheduled to be phased in through January 1, 2018 (5) costing a total of \$1.7 trillion (6) (Box 2). Title 8 (Community Living Assistance Supports and Services) was abandoned by the Obama Administration on October 15, 2013 on the grounds that it would not be financially viable (7). The 5% cosmetic surgery tax in Title 9 was also subsequently repealed, as it was felt to disproportionately affect the middle class and women (8). There have been many other modifications to the ACA since initial implementation and this article attempts to provide the most current account of the bill.

Key Aspects of the ACA

Access

The ACA is estimated to increase the number of Americans with health insurance by 32 million by the year 2019 (9). There are multiple avenues through which the ACA attempts to achieve this goal. The most notable measure is by expanding Medicaid eligibility to Americans in a wider income bracket; this alone is estimated to result in 16–18 million newly insured (10). Medicaid eligibility will be expanded to up to 133% of the poverty line. Further, tax credits will be available for the purchase of health insurance for people between with incomes between 100% and 400% of the poverty line (9). The ACA also limits insurance exclusions, prevents the use of lifetime caps on insurance, makes it illegal to deny insurance coverage for those with preexisting conditions, and allows insurance coverage for children on parental plans up to the age of 26 (9).

Beginning in 2014, individuals are required to purchase health insurance (i.e. the “individual mandate”) (11). Failing to obtain insurance coverage will lead to a fine that begins at \$95 or 1% of taxable income in 2014. This increases in 2016 to a maximum of \$695 for individuals (three times that for families) or 2.5% of income, whichever is greater (10). Beginning in 2015, employers of 100 employees will pay a fine if they do not offer minimum-value, employee-only coverage for any of their workers (i.e. the “employer mandate”) (12). The employer mandate will be delayed until 2016 for businesses with between 50–99 employees. To minimize the economic impact on small businesses, these companies may apply for the Small Business Health Care Tax Credit (13). Penalties resulting from these mandates are anticipated to provide a substantial source of revenue to pay for the ACA.

A state-based health care exchange was implemented in 2014. These exchanges are marketplaces where uninsured individuals and businesses can comparison shop for insurance policies (3). Variability in health care exchange prices are allowed to vary based

only upon patient age, geographic area, family composition, and tobacco use. Further, the insurance industry must use 85% of premiums directly for costs of delivering medical care (10), and must provide rebates to enrollees if they spend less than 85% on healthcare as opposed to administrative costs (14).

Cost

Providing care to current and new Medicare and Medicaid enrollees will come at a considerable cost. Estimates indicate that the Centers for Medicare and Medicaid Services (CMS) will reduce payments to hospitals by \$158 billion over 10 years to help defray the cost of the newly insured (9). Overall health expenditures are projected to reduce by \$600 billion over the same time frame (15). The authors of the law sought to finance nearly half of the cost of the ACA through Title 9 provisions. These include new Medicare taxes on high-income wage earners, and new taxes on pharmaceutical manufacturers, health insurance providers, and medical device manufacturers. The ACA does not mandate fee restructuring for service reimbursement, but does give the Secretary of Health and Human Services authorization to adjust “misvalued” fee schedules or procedures and services that have experienced high growth or advances in technology (9). Changes in payment structures will clearly influence how physicians practice and how care is delivered. Despite the American College of Surgeons’ (ACS) recommendation to institute potentially cost-saving medical liability reform with the passage of the ACA, no provisions were included (16). The implementation of independent panels and regulatory reforms are other ACA strategies to save money.

Independent Payment Advisory Board (IPAB)—The IPAB is a board of impartial experts charged with establishing specific target growth rates for Medicare and ensuring that Medicare expenditures stay within these limits. This board is comprised of 15 members appointed by the President for a 6-year term (17). Members are supposed to be nationally recognized experts in health finance, payment, economics, actuarial science, or health facility and health plan management, and to represent providers, consumers, and payers (3). There is no mandate for a health care provider (e.g. physician, nurse, etc) to be present on the Board and there is no congressional authority over the IPAB. However, Congress may increase Medicare funding independently through legislation. This IPAB is prevented from reducing Medicare benefits, raising premiums or taxes, or rationing care. The IPAB is not, however, prohibited from cutting payments for physicians (17). It is clear that a disproportionate share of these savings will come from surgical services relative to the rest of medicine (18).

Regulatory Reform and Combating Waste—The U.S. healthcare system is the world’s largest and most inefficient information enterprise (19). In 2009, Thomson-Reuters estimated that the system wastes between \$505 and \$850 billion annually, reflecting one-third of the nation’s healthcare bill (20). This occurs despite the annual investment of almost \$170 billion in health services regulation (21). The elimination of paper-based medical records in favor of electronic systems alone is estimated to save hospitals and physician practices \$371 billion and \$142 billion, respectively over 15 years (19). Other approaches to combating waste include increased federal sentences (by 20–50%) for healthcare fraud over

\$1 million and enhanced screening (e.g. license checks, site visits) of providers who pose a higher risk of fraud (6). A controversial change in the law now states that a person need not have actual knowledge of this section or specific intent to commit a violation of this section in order to be charged with healthcare fraud (5). To avoid unintentional healthcare fraud and a possible audit, providers should (1) avoid copying and pasting notes (cloning) in electronic medical records, (2) only document services they actually provide and avoid upcoding, (3) and always review billing practices to ensure compliance.

Quality

In 2013, the CMS began to distribute a total of \$850 million to hospitals as a reward for meeting a series of quality measures (9). These funds were generated by reducing the diagnosis-related group (DRG) payments for all hospitals, and then redistributing the savings based on hospital performance. Under the controversial inpatient Value-Based Purchasing Program (VBPP), hospitals are assessed by means of 12 clinical quality measures in 6 domains (patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources, and clinical processes/effectiveness) and a composite measure of patient experience (22). The VBPP is used to decrease payments to hospital providers not meeting certain quality standards established by the CMS (16).

Physicians will also be increasingly responsible for submitting quality data to the CMS in exchange for payment. The CMS introduced the Physician Quality Reporting System (PQRS) to deliver incentive to providers who enter quality data for review. In 2014, individual providers who satisfactorily submit PQRS quality measures will qualify to earn an incentive payment equal to 0.5% of their total estimated Medicare Part B Physician Fee Schedule (PFS) reimbursements. As of 2015, however, eligible physicians or group practices not submitting PQRS data will be paid 1.5% less (2.0% less in 2016) than the Medicare PFS for that service (23).

In addition to direct tracking of hospital and individual provider quality measures, quality improvement was addressed in the ACA via the formation of various agencies. The aims of these new entities are to examine current and future strategies for health care delivery and payment, as well as comparative effectiveness of currently available treatments. Further, Accountable Care Organizations (ACOs) were incorporated into the ACA in an effort to give incentives to physicians and hospitals to promote higher quality, lower cost healthcare. The ACS, however, warned that caution should be used before using quality and outcomes measures to drive coverage or reimbursement. In 2012, they expressed that quality measures are necessary, but have not been adequately tested and risk-adjusted to serve as a foundation for policy and reimbursement decision-making (24).

Patient-Centered Outcomes Research Institute—Established in 2010, the Patient-Centered Outcomes Research Institute (PCORI) focuses on funding and promoting comparative effectiveness research (25) (Box 3). The anticipated results will assist healthcare professionals and policy makers in making more informed decisions. As the

PCORI has no role in reimbursement decisions, studies funded by this entity are specifically prohibited from examining cost effectiveness (26).

Center for Medicare and Medicaid Innovation—In 2010, the ACA established the \$10 billion Center for Medicare and Medicaid Innovation with the goal of testing care models that have the potential to improve quality of care and reduce costs (27). A major focus is on the development of “bundled payments” for entire episodes of care involving multiple providers across different settings, rather than for discrete services by individual healthcare providers (9). As a result, there would be an incentive to coordinate care among providers of different specialties; sharing reimbursement within the confines of this model is an issue that has yet to be clarified.

Accountable Care Organizations—ACOs are networks of healthcare providers that assume accountability for coordination and delivery of effective, high-quality care through a more efficient use of resources (28). This new patient care model arose in the 1990’s in response to the inability of the sustainable growth rate (SGR) to limit spending growth on physician services (29). The ACA outlines specific requirements that must be met to be designated as an ACO (Box 4) (30). Unique features of ACOs include the fact that patients can choose their own providers, keep their insurance, and stay in the Medicare program. By achieving quality improvements and slowing resource utilization, ACOs are remunerated by CMS at an amount equal to a percentage of money saved through cost efficiency (28). There are currently more than 350 ACOs participating in Medicare (31). According to CMS estimates, ACO implementation through the ACA is estimated to lead to savings of \$470 million from 2012–2015 (32). Importantly, 7 of the original 32 Pioneer ACO’s, including our own institution (the University of Michigan), have dropped out of the program because no savings were realized in 2012 (33).

Impact of ACA Policies on Hand Surgeons

In addition to the innumerable changes already occurring in the healthcare landscape as a result of the passage of the ACA, many provisions have direct implications for current and future hand surgeons.

Graduate Medical Education

With the signing of the ACA, the government took on a new obligation to ensure millions of people have access to health care. These newly insured patients will seek care from physicians just as funding for graduate medical education (GME) has stagnated. As a result, it is doubtful that there will be a sufficient number of residency positions available to train the necessary future physician workforce (34, 35). This is particularly worrisome for surgical subspecialties because nearly all efforts at increasing GME funding are directed at primary care.

Payments

Primary care physicians are slated to receive a 10% Medicare bonus for 5 years (2011–2015) under the direction of the ACA. A similar bonus was provided to general surgeons

practicing in underserved areas (34). Conversely, there is a mandated reduction in payments for all other surgical services and the elimination of the disproportionate share hospital (DSH) program payments by Medicare and Medicaid (9). A DSH is a facility that treats a disproportionate number of indigent patients. The program sought to encourage these hospitals to continue to provide quality services to vulnerable patients by providing funding for uncompensated care (36). This situation is made more complex by the fact that 24 states have opted out of the Medicaid expansion (these states will lose the benefit of both the DSH and additional Medicaid-covered patients) (37). In aggregate, these changes will disproportionately affect surgeons, particularly those who practice in safety-net hospitals (i.e. a facility that provides a substantial level of care to low-income, uninsured, or vulnerable populations). Lastly, the ACA will restrain revenues from ancillary services (in-office imaging) and through a modified Stark law prohibiting physicians from referring to a hospital in which they have a financial stake (38).

Tax Increases

With the implementation of the ACA, several new taxes began starting in 2013. Of these, the 2.3% medical device excise tax will likely impact many hand surgeons; this tax is levied on devices ranging from surgical gloves, instruments, plates and screws for osteosynthesis, joint replacement implants, and advanced imaging technology (39). Costing manufacturers an estimated \$7 billion from 2013–2015 (40), some have proposed that this tax may result in considerable harm to research, development, and employment in the medical device industry (41). In 2012, Stryker (Kalamazoo, MI) announced that it would lay off more than 1,000 employees as a result of the estimated fiscal impact (42). Further, it is possible that the increasing costs of medical devices may be passed on to patients.

Other newer taxes directly affect many surgeon's businesses and personal finances. For example, starting in 2013, the Medicare tax on wages increased by 0.9% to a total of 3.8% of income greater than \$200,000 for an individual or \$250,000 for a married couple filing jointly. Hand surgeons in this income range are also responsible to pay a new 3.8% Medicare tax on capital gains, dividends, and other passive income. Health flexible spending accounts are now limited to a maximum of \$2,500 annually, whereas the medical expense deduction threshold was increased from 7.5% to 10% of income (43).

Conclusions

The ACA is one of the most comprehensive, expensive, and impactful bills signed in the history of the United States. Health insurance coverage is now extended to millions of individuals not previously covered by a health plan. Using a variety of approaches, the ACA attempts to control costs by regulating healthcare delivery and reimbursement. The many statutes of the ACA will directly impact all current and future hand surgeon practices and incomes through new taxes on high-income earners and requisite adherence to incompletely defined quality standards. Playing an active role in the development of quality benchmarks and comparative effectiveness research, lobbying for increased GME funding and medical liability reform, and developing more efficient ways of delivering high-quality care will help

the specialty transition into the future of U.S. healthcare. Whether these sweeping changes prove fiscally responsible while improving patient care has yet to be determined.

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Key Points

1. The Affordable Care Act has three goals: provide healthcare for all Americans, control costs of healthcare, and improve the quality of healthcare.
2. To achieve these goals, the governments has instituted (1) an individual and business mandate, (2) federal subsidies for healthcare, (3) new requirements on the health insurance industry, and (4) changes in the practice of medicine.
3. The Affordable Care Act also provides new funding for comparative effectiveness research, ties quality measures to reimbursement, and increases taxes on high-income wage earners and medical device manufacturers.

Box 1Goals of ACA

- 1 Provide healthcare for all Americans
- 2 Control costs of healthcare
- 3 Improve the quality of healthcare

Essential Components of ACA

- 1 Individual and business mandate
- 2 Federal subsidies for health insurance for uninsured patients
- 3 Extensive new requirements on health insurance industry
- 4 New regulations on the practice of medicine

Box 2**The 10 Titles of the Affordable Care Act**

Number	Title	Principal Effects
I	Quality, Affordable Health Care for all Americans	Removal of coverage exclusions based on preexisting conditions, gradual elimination of fee-for-service vs. prevention and diminished inpatient and procedure-based care
II	The Role of Public Programs	State-based opt out of Medicaid, Disproportionate Share Hospital program elimination, requirement of “essential health benefits”
III	Improving the Quality and Efficiency of Health Care	Health care that is more efficient, effective, and patient-centered; implementation of electronic health records and integration of healthcare databases; medical technology targeted as primary factor for rising costs, especially technology that does not increase health care value; formation of Independent Payment Advisory Board; drive to reorganization of care (Accountable Care Organizations and integrated departments) will affect surgeons
IV	Prevention of Chronic Disease and the Improvement in Public Health	Refocusing health care on prevention of disease, with implications for surgeons
V	Health Care Workforce	Currently, National Health Care Workforce Commission not funded (held up in the House of Representatives); significant effect on surgical subspecialists if not convened
VI	Transparency and Program Integrity	Addressing health care cost inefficiency and fraud; Sunshine Provision for physician payment reporting; Patient-Centered Outcomes Research Institute support of research on comparative effectiveness
VII	Improving Access to Innovative Medical Therapies	New Food and Drug Administration regulatory pathways; most profound opportunity is in “just-in-time” clinical research based on national databases
VIII	Community Living Assistance Supports and Services: CLASS	This title was abandoned by the Obama administration on October 15, 2013
IX	Revenue Provisions	This title finances approximately half of the ACA; factors affecting hand surgeons are new Medicare taxes on high-income wage earners and new taxes on pharmaceutical and medical technology device manufacturers
X	Strengthening Quality, Affordable Health Care for All Americans	Amendments and additions to Titles I–IX, passed as the Health Care and Education Reconciliation Act signed on March 30, 2010

(Adapted with permission from Ferguson TB Jr, Babb JA. The affordable care act: implications for cardiothoracic surgery. *Semin Thorac Cardiovasc Surg*. 2013 Winter; 25(4): 280-6.)

Box 3PCORI Priorities

- 1 Assessment of options for prevention, diagnosis, and treatment
- 2 Improving healthcare systems
- 3 Communication and dissemination research
- 4 Addressing disparities
- 5 Accelerating PCOR and methodological research

PCORI Criteria

- 1 Impact on the health of individuals and populations
- 2 Improvability via research
- 3 Inclusiveness of different populations
- 4 Addresses current gaps in knowledge/variation in care
- 5 Impact on health care system performance
- 6 Potential to influence decision making
- 7 Patient-centeredness
- 8 Rigorous research methods
- 9 Efficient use of research resources

Box 4Criteria Summary for Designation as an ACO

- 1 Express willingness to be accountable for quality, cost, and overall care of Medicare beneficiaries for minimum of 3 years
- 2 Minimum of 5,000 Medicare beneficiaries with a strong core of primary care physicians
- 3 Legal structure to receive and allocate payments
- 4 Report on quality, cost, care coordination measures, and meet patient-centeredness criteria

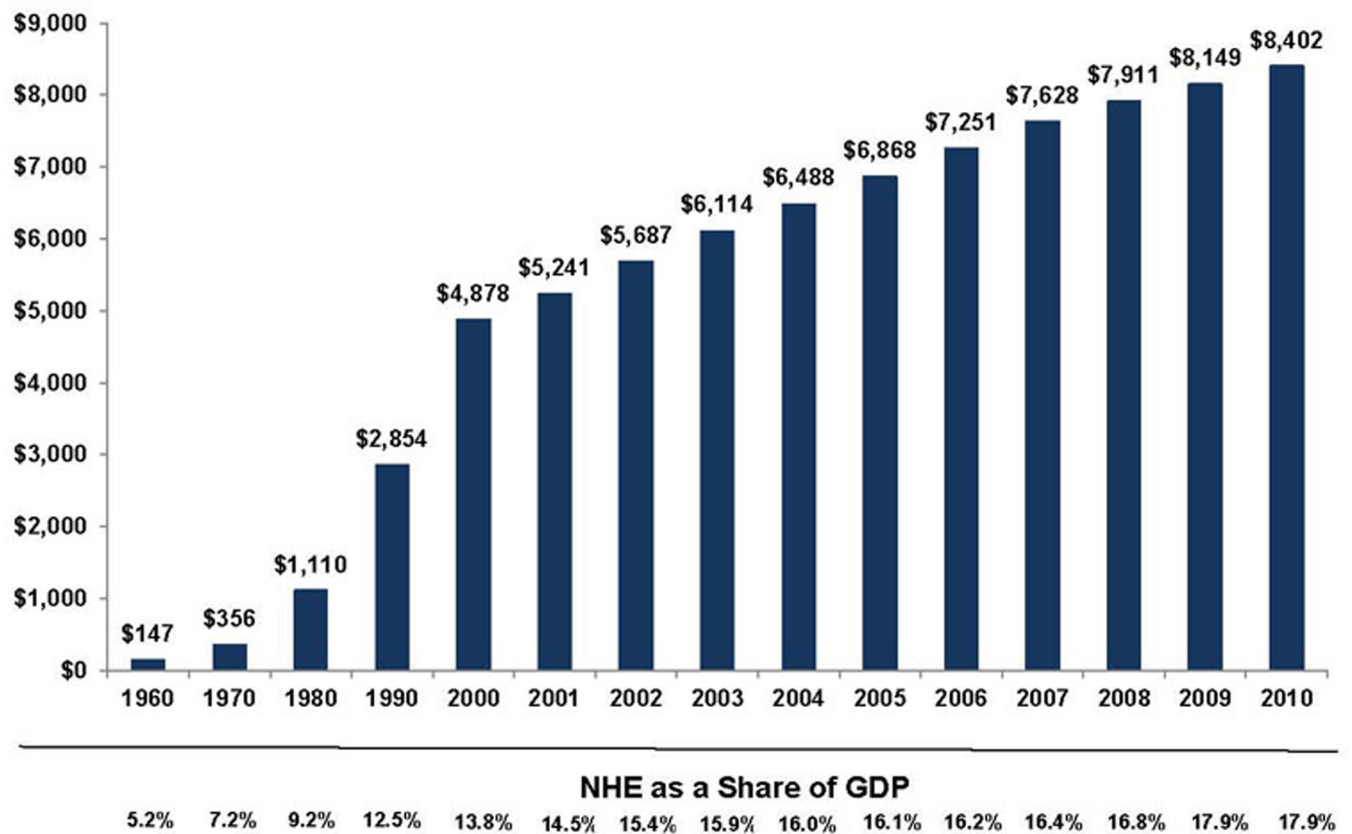


Figure 1.

National Health Expenditures per Capita, 1960–2010 (Adapted from: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960–2010; file nhegdp10.zip)